# State of Maryland – UnitedHealthcare Options

**Coverage Period: 7/1/2013 – 12/31/2013**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage level:** Employee/Retiree & Family | **Plan Type:** PPO

**This is only a summary. Due to the Short Plan Year coverage period (so the State can change to a calendar year), all deductibles and out-of-pocket limits are cut in half to accommodate the six month timeframe.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan documents at www.dbm.maryland.gov/benefits or by calling 410-767-4775 or 1-800-307-8283.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | Per plan year: In-Network: **None**<br>Out-of-Network: **$125** per Individual/ **$250** per Family<br><br>Does not include copays and is separate from coinsurance. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you receive out-of-network. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | In-network: **$500** per Individual / **$1,000** per Family;<br>Out-of-network: **$1,500** per Individual / **$3,000** per Family | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for healthcare expenses. |
| **What is not included in the out–of–pocket limit?** | Premium, copayments, **balance-billed** charges, healthcare not covered under this plan and penalties for failure to obtain preauthorization for services. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of in-network **providers**, see www.myuhc.com or call **1-800-382-7513.** | If you use an in-network doctor or other healthcare **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. However, your costs will be different for an in-network specialist than an out-of-network specialist. |
| **Are there services this plan doesn't cover?** | Yes | Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**. |

**Questions: Call 410-767-4775 or 1-800-307-8283 or email us at EBDMAIL@dbm.state.md.us or visit us at www.dbm.maryland.gov/benefits**
**If you aren't clear about any of the bolded & underlined terms used in this form, see the Glossary at www.dbm.maryland.gov/benefits**

- **Copayments** (copays) are fixed dollar amounts (for example, $15) you pay for covered healthcare, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight in-network hospital stay is $1,000, your **coinsurance** payment of 10% would be $100
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a healthcare provider's office or clinic** | Primary care visit to treat an injury or illness | $15 copay | 30% coinsurance after deductible | If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply. |
| | Specialist visit | $30 copay | 30% coinsurance after deductible | If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply. |
| | Other practitioner office visit | Acupuncture & Chiropractic: $20 copay | 30% coinsurance after deductible | Acupuncture is only covered for chronic pain management. Preauthorization required |
| | Preventive care/screening/immunization | No Charge | 30% coinsurance after deductible | Age and frequency schedules may apply. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | 30% coinsurance after deductible | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 30% coinsurance after deductible | ——————none—————— |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.express-scripts.com or by calling 1-877-213-3867. | Generic drugs | $10 copay (1-45 day supply); $20 copay (46-90 day supply) | Not Covered | **Outpatient Prescription Drug coverage is not included in your medical plan.** You elect this coverage separately from your medical plan. The plan is administered by Express Scripts; you receive a separate ID card and pay a separate premium for prescription coverage.<br><br>Review the State of Maryland's website at www.dbm.maryland/benefits for more details. |
| | Preferred brand drugs | $25 copay (1-45 day supply); $50 copay (46-90 day supply) | Not Covered | |
| | Non-preferred brand drugs | $40 copay (1-45 day supply); $80 copay (46-90 day supply) | Not Covered | |
| | Specialty drugs | Copay and drug supply limit varies by type of drug. | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance after deductible | Must be preauthorized by plan. |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance after deductible | Must be preauthorized by plan. |
| **If you need immediate medical attention** | Emergency room services | Facility: $75 copay<br>Physician: $75 copay | Facility: $75 copay<br>Physician: $75 copay | Copay waived if admitted. If criteria are not met for a medical emergency, the plan coverage is 50% after copays. |
| | Emergency medical transportation | No Charge | No Charge | Non-emergency use: 10% coinsurance in-network; 30% coinsurance out-of-network. |
| | Urgent care center | $30 copay | 30% coinsurance after deductible | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance after deductible | Preauthorization required<br>20% non-compliance penalty |
| | Physician/surgeon fee | 10% coinsurance | 30% coinsurance after deductible | |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $15 copay per visit | 30% coinsurance after deductible | Behavioral health benefits are administered by APS Healthcare; You must be enrolled in the medical plan in order to have these benefits. You will receive a separate ID card for this coverage. |
| | Mental/Behavioral health inpatient services | 10% coinsurance | 30% coinsurance after deductible | |
| | Substance use disorder outpatient services | $15 copay per visit | 30% coinsurance after deductible | |
| | Substance use disorder inpatient services | 10% coinsurance | 30% coinsurance after deductible | |
| **If you are pregnant** | Prenatal and postnatal care | No Charge | 30% coinsurance after deductible | Additional copays or preauthorization requirements may apply to postnatal care. |
| | Delivery and all inpatient services | 10% coinsurance | 30% coinsurance after deductible | Additional copays, deductible, co-insurance or notification requirements may apply. |
| **If you need help recovering or have other special health needs** | Home healthcare | 10% coinsurance | 30% coinsurance after deductible | Limited to 120 days per plan year. |
| | Rehabilitation services | $30 copay per visit | 30% coinsurance after deductible | Limited to 50 combined visits per plan year for Speech, Occupational, and Physical Therapy. Must be preauthorized by plan. |
| | Habilitative services | $30 copay per visit | 30% coinsurance after deductible | No limit of treatment for children under 19 with congenital or genetic birth defects including autism, autism spectrum disorder, and cerebral palsy. Must be preauthorized by plan. Over age 19 members visits are limited to 50 combined visits for therapies. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs (continued)** | Skilled nursing care | 10% coinsurance | 30% coinsurance after deductible | Limited to 180 days per plan year. Must be preauthorized by plan. |
| | Durable medical equipment | 10% coinsurance | 30% coinsurance after deductible | Preauthorization required if over $1,000. |
| | Hospice service | 10% coinsurance | 30% coinsurance after deductible | Must be preauthorized by plan. |
| **If your child needs dental or eye care** | Eye exam | No charge - Up to a maximum of $45 | No charge - Up to a maximum of $45 | Coverage is limited to one routine eye exam per plan year up to $45. Non-routine eye exam copay is $15 per visit. |
| | Glasses | Please refer to your contract or the online Benefits Guide for coverage details. | Please refer to your contract or the online Benefits Guide for coverage details. | Frames: Plan pays $45 once per plan year; Member pays balance. |
| | Dental check-up | Covered under separate dental plan. Two types are offered: dental HMO and dental PPO | Out-of-network coverage available under the DPPO plan only. | Dental benefits are administered by United Concordia; you receive a separate ID card and pay a separate premium for dental coverage. **You must enroll in one of the dental plans to have dental coverage.** For more information call United Concordia at 1-888-638-3384 or www.unitedconcordia.com/statemd. |

## Excluded Services & Other Covered Services:

| **Services Your Medical Plan Does NOT Cover. (This isn't a complete list. Check your policy or plan document for other excluded services.)** | | |
|---|---|---|
| • Cosmetic surgery<br>• Routine Dental care (Adult/Child) | • Long-term care<br>• Weight loss programs (Nutritional counseling is covered) | • Outpatient prescription drug<br>• Routine foot care |
| **Other Covered Medical Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)** | | |
| • Immunization & preventative screenings (covered in full in-network only)<br>• Bariatric surgery | • Home healthcare<br>• Hearing aids covered once every 36 months with limitations | • Infertility Treatment – Artificial insemination and In vitro. Infertility treatment limited to 3 attempts, not to exceed a $100,000 lifetime maximum. Other restrictions apply. Refer to your policy and plan documents or the online benefits guide. |

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Employee Benefits Division at 1-800-307-8283. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Employee Benefits Division at 410-767-4775, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, the Office of Health Insurance Consumer Assistance can help you file an **appeal**. Contact information: 1-877-261-8807; heau@oag.state.md.us; or http://www.oag.state.md.us/Consumer/HEAU.htm

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,850
- **Patient pays** $690

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Medical Copayment | $0 |
| Prescription Copayment | $20 |
| Coinsurance | $520 |
| Limits or exclusions | $150 |
| **Total** | **$690** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,630
- **Patient pays** $770

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Medical Copayment | $150 |
| Prescription Copayment | $400 |
| Coinsurance | $140 |
| Limits or exclusions | $80 |
| **Total** | **$770** |

**The coverage examples are based on the experience of one covered member or dependent regardless of coverage level.**

# Questions and Answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as flexible spending accounts (FSAs) that help you pay out-of-pocket expenses.